BRIEFING

MEDICAL LAW

May 2020

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INTRODUCTION

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Daily life continues to be dominated by the widespread impact of Coronavirus. In this briefing we bring you a round-up of some of the ways in which coronavirus is having an impact on litigation and Medical Law.

Ella Davis and Sarah Prager look at the MDU's request for a debate on immunity from lawsuits arising from care provided during the current pandemic; a two sided coin with no easy answer.

Dominique Smith analyses the Chief Coroner's Guidance No.37 and Richard Collier helpfully summarises the approach courts are taking to applications for extensions of time and remote hearings.

As ever, at 1 Chancery Lane our barristers and clerks are working hard to provide a full and consistent service. Please do not hesitate to contact us in Chambers and remember that we have our legal advice helpline for as long as the lockdown continues https://1chancerylane.com/free-legal-advice-helpline/

Best Wishes

LIMITING HEALTHCARE WORKERS' LIABILITY: CLAIMS ARISING FROM THE COVID-19 PANDEMIC

SARAH PRAGER

ELLA DAVIS

The MDU is calling for a debate on whether emergency legislation should be enacted to provide healthcare professionals with immunity from lawsuits arising from care provided during the current pandemic, pointing to the fact that many professionals are risking their lives providing care in incredibly challenging circumstances.

Under s.11 of the Coronavirus Act 2020 the Secretary of State has the power to indemnify, or make arrangements to indemnify, healthcare workers (and others) in relation to any claims in tort for damages for death or personal injury arising out of the provision of 'relevant services', which are defined in s.11(3) as:

"a service which is provided by a person as part of the health service and which—

(a) relates to—

(i) caring for or treating a person who has, or is suspected of having, coronavirus disease, whether or not in respect of that disease,

(ii) caring for or treating a person (other than a person within sub-paragraph (i)) who has been, or is suspected of being, infected or contaminated, in respect of that infection or contamination or suspected infection or contamination, or

(iii) diagnosing or determining whether a person has been infected or contaminated,

(b) relates to diagnosis, care or treatment and is provided in consequence of another person who usually provides such a service (other than one within paragraph (a)) as part of the health service being unable to do so in consequence of providing a service within paragraph (a), or

(c) relates to diagnosis, care or treatment and is provided in consequence of another person who usually provides such a service as part of the health service being unable to do so because of a reason relating to coronavirus."

Setting to one side for a moment the mangled syntax of ss.11(3)(b) and (c), the intention appears to be the protection of healthcare professionals caring for coronavirus patients and for patients (such as cancer patients) who cannot be treated in the usual way as a consequence of the pandemic, and whose condition deteriorates as a result. The Secretary of State is empowered to authorise an individual to determine whether any claim falls within s.11, and if so, whether mistakes have been made, and the amount of any consequential payment. Similar provisions in ss.12 and 13 extend the indemnity to Scotland and Northern Ireland.

Practitioners do not feel that the provisions go far enough; the provisions only apply where there is no other indemnity available, for example by way of insurance, and it only applies to claims founded in tort. The individual empowered by the Secretary of State determines whether the indemnity is engaged, and if so, whether any payment should be made under the scheme, and there does not appear to be any appeal mechanism in relation to these decisions (although presumably a judicial review would be available in the case of an egregious error in the decision-making process). The provisions are silent in relation to the costs incurred by the healthcare provider in investigating and defending any claim made, and it is not clear whether the costs of any claimant would be payable or not; if not, even if the indemnity *were* engaged in any particular case, the practitioner could still end up significantly out of pocket.

Furthermore, as the MDU has pointed out, even if they are indemnified, claims against healthcare professionals are a time consuming and distressing experience, as they are for any defendant. The cost of the scheme is also likely to be an issue; it is difficult to predict how many coronavirus and other patients would be likely to make claims, and there is no indication of the aggregate value of them. What *is* known is hardly encouraging; screening for cervical cancer, for example, has been suspended in Scotland, Wales and Northern Ireland, and whilst in England screening has not been formally

stopped, in practice very little is now taking place. Research undertaken by University College London suggests that almost 18,000 people could die over the next year in England from cancer alone as a result of the secondary impact of the pandemic, and patients have spoken of feeling 'abandoned' by the system. Clearly there is the potential for significant litigation to arise.

It is against this background that the MDU has called for the impact of Covid-19 related claims on medical practitioners' health and wellbeing to be recognised, and for medical professionals to be granted immunity from litigation arising from the healthcare they are currently providing in the context of the pandemic.

The obvious counter to this suggestion is to ask why a claimant who has suffered negligent treatment should be deprived of their right to claim. There is already a high bar in proving negligence given that the Bolam test requires the claimant to prove that the clinician acted in a manner in which no responsible body of practitioners would have acted. In determining whether care was reasonable the courts will take account of the circumstances in which the clinicians were working. For example, previous cases have taken account of the availability of resources (including *Ball v Wirral HA [2003] Lloyd's Rep. Med. 165*, partly concerning the availability of ventilation). If, therefore, making due allowance for the circumstances, care fails to meet the standard of any responsible body of clinicians, why should an injured claimant not be compensated?

The MDU observes that cases will usually be tried long after the current situation has resolved, and memories of the scale of the crisis have faded. It will certainly be important for both parties in future claims to lead evidence from experts who have given due consideration to the circumstances of the pandemic. Those acting for defendants will also want to try to obtain evidence of the available resources (including staff numbers) at the time the care was provided.

One issue where problems may particularly arise is in relation to people acting outside of their usual practice. Medical students have started treating patients sooner than they usually would, and people who had left the NHS have gone back into service. Some clinicians are covering other specialisms. However, as the law currently stands the standard of care for a particular task is held to be the same no matter who performs the task (*FB v Rana [2017] EWCA Civ 334*). Further, whatever their experience or specialist training, clinicians will be judged against the standard expected of competent practitioners in the role they are fulfilling (see Jackson LJ in *FB v Rana)*. It would obviously be concerning if healthcare professionals who have stepped up in a crisis are unduly worried about being sued for performing tasks they would not normally perform. Such worries would potentially be detrimental to patient care and undoubtedly harmful to the wellbeing of clinicians already under unprecedented pressure.

Whether a formal immunity is the answer to their concerns is, as the MDU acknowledges, debatable. However, the suggestion raises interesting questions to be grappled with concerning how to balance patients' rights to compensation for substandard care, with the public and individual interest in not loading more strain onto already stretched healthcare professionals and public finances.

About the Authors

Called to the Bar in 1997, Sarah Prager acts for Claimants and Defendants in personal injury claims, specialising in cross border disputes. In the clinical negligence field she has expertise in surgical tourism, having been involved in a number of claims arising out of cosmetic surgery alleged to have been negligently performed.

Ella Davis was called in 2013 and acts as junior counsel and in her own right in a range of clinical negligence claims, acting both for Claimants and Defendants. She has a particular interest and expertise in cases relating to birth and maternal injuries, wrongful birth and cancer. She is frequently asked to act in cases raising complex causation issues, including injuries resulting in chronic pain.

CORONAVIRUS, PPE AND INQUESTS: A FURTHER UPDATE FROM THE CHIEF CORONER

DOMINIQUE SMITH

Many of us around the world have been on lockdown for several weeks. We have been unable to see our relatives, close friends, and colleagues, all in the name of reducing the possibility of us (and others) succumbing to COVID-19.

The protection many of us have been afforded through social distancing does not extend to keyworkers. They continue to work on the frontline, in the knowledge that they may be interacting with those already infected. Whilst measures have been taken to reduce their risk of contracting the disease, much debate has arisen as to whether these measures are sufficient. For example, the adequacy of Personal Protective Equipment ("PPE"), or indeed the lack of it, has been at the forefront of global news headlines during the coronavirus pandemic.

It is inevitable that some keyworkers will not only contract COVID-19 but will also fail to win their battle against the disease. In those instances, should a coroner open an inquest, particularly if there are concerns that the lack of PPE has contributed to the keyworker's death?

The Chief Coroner has recently released further guidance in the form of Guidance No. 37, which concerns coronavirus and possible exposure in the workplace. It touches upon issues including PPE and whether a death from COVID-19 should give rise to the need for an investigation.

When will a death from COVID-19 be referred to the coroner?
The Chief Coroner has re-emphasised that COVID-19 is a naturally occurring disease. As such, most deaths from COVID-19 would not normally be investigated at an inquest.

However, that is not to say that all COVID-19 deaths will not be investigated. If a medical practitioner suspects at the time of certifying a death that the death was due to "*…an injury or disease attributable to any employment held during the person's lifetime*", that medical practitioner must report the death to the coroner, pursuant to Regulation 3(1)(a) of the Notification of Deaths Regulations 2019.

As such, the death of an individual working on the frontline during the pandemic could be referred to the coroner, if the medical professional is of the view that the COVID-19 infection leading to their death was attributable to their place of work. The guidance makes plain that frontline workers do not just include NHS staff, but may also include public transport employees, care home workers and emergency service personnel. This list, however, is not exhaustive.

When will an investigation be opened?
Firstly, the coroner must consider whether an investigation should be conducted into the individual's death. Unless there is any reason to suspect that human failure contributed to their death, it is unlikely they will open an investigation.

If the coroner has a "*reason to suspect that… the deceased died… [an] unnatural death*", the death must be investigated. The test of having "reason to suspect" is one that has a low threshold, requiring only grounds for surmising. Ultimately, whether an investigation is necessary depends on whether the coroner considers that the facts and evidence in the case point to the death being unnatural.

The guidance helpfully gives examples as to when a death may be considered unnatural. For example, if there was a reason to suspect that human failure contributed to the deceased becoming infected with COVID-19, or if there were any failures of precautions in the workplace which caused the deceased to contract the virus and so contributed to their death, an investigation and inquest may be required.

Will issues concerning PPE and public policy be explored at the inquest?
It is a matter of judgment for each coroner to decide on the scope of an inquest. However, the Chief Coroner

reminds coroners within the guidance that an inquest is not the correct forum for addressing concerns about high-level government or public policy. Consequently, it is not for a coroner at an inquest to consider whether adequate arrangements were in place for the provision of PPE.

However, if a coroner considers that the investigation of an individual's death requires evidence to be obtained in relation to policy and resourcing, which may include evidence of the adequacy of provision of PPE for medical professionals in a hospital, the coroner may suspend the investigation until it is clear how the coroner's enquiries can best be pursued. As medical professionals remain under significant demand during the pandemic, coroners should be sensitive to this.

Conclusion

The guidance provides much-needed clarification in respect of COVID-19 deaths and the inquest process. Yet, it will no doubt cause great concern to the families of deceased frontline keyworkers, who may feel that the scope of the inquest is being unnecessarily curtailed. Nonetheless, it seems that the appropriate forum for those concerns to be aired will be in the form of a public inquiry.

About the Author

Dominique Smith was called in 2016 and acts for both Claimants and Defendants in clinical negligence claims. Dominique has a particular interest and expertise in cases involving a failure to diagnose and a failure to obtain informed consent. Dominique also has a busy practice in the Coroners Court, frequently acting for NHS Trusts, as well as families. Dominique has acted in a number of Article 2 inquests, as well as those involving a jury, and has secured findings of neglect.

MUNCIPIO DE MARIANA & ORS V (1) BHP GROUP PLC (FORMERLY BHP BILLITON) (7) BHP GROUP LTD (SECOND TO SIXTH DEFENDANTS NOT PARTY TO THE PROCEEDINGS) [2020] EWHC 928 (TCC)

RICHARD COLLIER

Whilst the facts of this case are far removed from medical law, this is a useful case which brings together and summarises the approach to be taken by the courts and parties when an application for an extension of time is made because of disruption caused by Covid-19.

In short, this group action arose out of the collapse of a dam in Brazil and the consequential release of toxic materials and contaminated water. The instant hearing involved the Defendants applying for an extension of time of 5-6 weeks for serving evidence in respect of the Claimant's application to stay proceedings on jurisdictional grounds, because of the practical difficulties caused by Covid-19.

Judge Eyre QC, in the Technology and Construction Court of the QBD (often at the vanguard of the civil justice system), gave some incredibly useful guidance for how to approach covid-induced applications for extensions of time. For the time being, at least, this will be the roadmap for judges hearing these applications. Indeed if I were conducting such a hearing as counsel, I would direct my submissions to the points below.

The Judge emphasised that, as ever, the starting point is the overriding objective. Regard must also be had to PD 51 ZA para 4 which requires the court to take into account the impact of the Covid-19 pandemic so far as compatible with the proper administration of justice. Directing himself to the authorities since the start of the pandemic, Judge Eyre QC elucidated the following principles as governing a) extensions of time and b) whether a particular hearing should be adjourned if the case could not be heard face-to-face or whether instead there should be a remote hearing:

The following principles apply to applications for extensions of time because of Covid-19:

a) The objective if it was achievable was to keep to existing deadlines and where that was not realistically possible to permit the minimum extension of time which was realistically practicable. The prompt administration of justice and compliance with court orders remained of great importance even in circumstances of a pandemic.
b) The court could expect legal professionals to make appropriate use of modern technology.
c) The court could expect and require from lawyers a degree of readiness to put up with inconveniences; to use imaginative and innovative methods of working; and to acquire the new skills needed for the effective use of remote technology.
d) The approach required of lawyers could also be expected from professional expert witnesses. However, rather different considerations were likely to apply where the persons who would need to take particular measures were private individuals falling outside those categories.
e) The court should be willing to accept less polished evidence and other material.
f) However, the court had to take account of the realities of the position and while requiring lawyers and other professionals to press forward care had to be taken to avoid requiring compliance with deadlines which were not achievable even with proper effort.
g) The court had to have regard to the consequences of the restrictions on movement and the steps by way of working from home which had been taken to address the pandemic.
h) Those factors were to be considered against the general position that an extension of time which required the loss of a trial date had much more significance and would be granted much less readily than an extension of time which did not have that effect.

As to the adjournment of hearings:

a) Regard was to be had to the importance of the continued administration of justice. Justice delayed was justice denied even when the delay resulted from a response to the prevailing circumstances.
b) There was to be a recognition of the extent to which disputes could in fact be resolved fairly by way of remote hearings.
c) The courts had to be prepared to hold remote hearings in circumstances where it would have been inconceivable only weeks earlier.
d) There was to be rigorous examination of the possibility of a remote hearing, and of the ways in which such a hearing could be achieved consistent with justice, before the court should accept that a just determination could not be achieved in such a hearing.
e) Whether there could be a fair resolution by way of a remote hearing would be case-specific. A multiplicity of factors would come into play and the issue of whether and to what extent live evidence and cross-examination would be necessary was likely to be important in many cases. There would be cases where the court could not be satisfied that a fair resolution could be achieved by way of a remote hearing.

About the Author

Richard was called to the bar in 2016. He acts for Claimants and Defendants across the full spectrum of clinical negligence work.

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